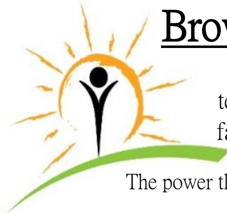

Brown Family Chiropractic Center
235 St. John Rd Suite 40 Fletcher, NC 28732
tel: 828-681-5454 WWW.GR8SPINE.COM
fax: 828-681-5054 email: drjon@gr8spine.com
The power that made the body heals the body

This Is All About Your Child...

Child's Name________________________________ Parent/Guardian's Name ___________________________

Address _______________________________________ City ______________ State ______ Zip ___________

Phone # 1: ___________________ Phone # 2:__________________ Birthdate ____/_____/_____ Age _____

Siblings- names/ages: ____

1. Has your child received previous chiropractic care? ☐ **YES** ☐ **NO** If yes, date of last adjustment: __________

   Previous chiropractor's name and location: ____

2. Current medical care? ☐ **YES** ☐ **NO** If yes, please explain: ____

3. Current medications (prescribed or over the counter): ____

4. Reason for consulting this office: ____

   ____

The human body is designed to express health and function normally. However, events may occur in life, which can interfere with this natural ability. This interference is most commonly the result of vertebral subluxations. Physical, chemical or emotional stress may cause these subluxations. The practice of chiropractic is based on the location and reduction of nerve system interference caused by vertebral subluxations.

Please answer the following questions and explain if necessary.

1. Were there any illnesses during pregnancy (mother or baby)? ☐ **YES** ☐ **NO**
2. Drugs/tobacco/alcohol used during pregnancy? ☐ **YES** ☐ **NO**
3. Medication during pregnancy? ☐ **YES** ☐ **NO**
4. Labor chemically induced? ☐ **YES** ☐ **NO**
5. Was there any pulling or twisting during delivery? ☐ **YES** ☐ **NO**
6. Forceps, Vacuum Extraction/C-section? ☐ **YES** ☐ **NO**
7. Premature delivery? ☐ **YES** ☐ **NO**
8. Vaccinations? ☐ **YES** ☐ **NO**
9. Did the child have Jaundice treatment? ☐ **YES** ☐ **NO**
10. Were there any eating or nursing problems? ☐ **YES** ☐ **NO**
11. Did your child have colic? ☐ **YES** ☐ **NO**
12. Sleeping problems? ☐ **YES** ☐ **NO**
13. Did the child have any falls in first year of life? ☐ **YES** ☐ **NO**
14. Other falls or injuries? ☐ **YES** ☐ **NO**
15. Respiratory problems? ☐ **YES** ☐ **NO**
16. Ear infections? ☐ **YES** ☐ **NO**
17. Does the child suffer from allergies/Asthma? ☐ **YES** ☐ **NO**
18. Digestive problems? ☐ **YES** ☐ **NO**
19. Hyperactivity? ☐ **YES** ☐ **NO**

20. Poor Nutrition? ☐ **YES** ☐ **NO**
21. Auto Accident or Injury? ☐ **YES** ☐ **NO**
22. Sports Injury? ☐ **YES** ☐ **NO**
23. Family/Home Stress? ☐ **YES** ☐ **NO**
24. Prescription Drug Use? ☐ **YES** ☐ **NO**
25. Non-Prescription Drug Use? ☐ **YES** ☐ **NO**
26. Has the child ever been hospitalized? ☐ **YES** ☐ **NO**
27. Any Major Illness? ☐ **YES** ☐ **NO**
28. Reoccurring Illnesses? ☐ **YES** ☐ **NO**
29. Motor Vehicle Accident ☐ **YES** ☐ **NO**
30. Surgery? ☐ **YES** ☐ **NO** ____
31. Any other health related problems? ______________________________________
____

Anything else Brown Family Chiropractic Center should know about your child?

____
____
____

Please list any fractures/broken bones, small/major accidents, head injuries AND dates that they occurred:

____
____

PLEASE CHECK THE CHOICE THAT MOST CLOSELY DESCRIBES CURRENT GOALS FOR YOUR CHILD'S HEALTH AND WELLBEING:

☐ I am only concerned about relief of a particular symptom for my child.
☐ I am only concerned about relief of a particular symptom, and preventing its return.
☐ I want optimum health and wellbeing on every level for my child.

- Are you willing to follow the doctor's recommendations? ☐ **YES** ☐ **NO**
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office manager. We accept check, cash, credit cards.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understanding. It is my responsibility to inform this office of any changes to the information I have provided.

Print Name: ____________________________________ **Relationship:** ______________

Signature: ____ **Date:** ______________

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be use to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: The state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer diagnose or treat any disease. We only offer to diagnose vertebral subluxations. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, ___________________________________ have read and fully understand the above statements.
(Parent/Guardian print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Consent to evaluate and adjust a minor child:

I, ____________________________________ being the parent or legal guardian of ___________________________________
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release: (if applicable)
This is to certify that to the best of my knowledge my child is not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle.

Parent/Guardian Signature ____ Date _____________

Witness: ____ Date:_________

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Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my child's protected health information (PHI) by Brown Family Chiropractic Center, P.A. for the purpose of diagnosing or providing treatment, obtaining payment for health care bills or to conduct health care operations of Brown Family Chiropractic Center, P.A. I understand that diagnosis or treatment of my child by Jonathan R. Brown, D.C. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my child's PHI is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Brown Family Chiropractic Center, P.A. is not required to agree with the restrictions that I may request. However, if Brown Family Chiropractic Center, P.A. agrees to a restriction that I request, the restriction is binding on Brown Family Chiropractic Center, P.A. and Jonathan R. Brown, D.C.

I have the right to revoke this consent, in writing, at any time, except to the extent that Jonathan R. Brown, D.C. or Brown Family Chiropractic Center, P.A. has taken action in reliance on this consent.

My child's protected health information (PHI) means health information, including personal demographic information, collected and created or received by a physician, another health care provider, a health plan, an employer or a health care clearinghouse. This PHI relates to my child's past, present and/or future physical or mental health condition and identifies, or there is a reasonable basis to believe the information may identify my child.

I understand I have a right to review Brown Family Chiropractic Center, P.A Notice of Privacy Practices prior to signing this document. Brown Family Chiropractic Center, P.A Notice has been made available to me at the office front desk and electronically on the website.

Brown Family Chiropractic Center, P.A. reserves the right of change the privacy practices that are described in the Notice of privacy Practices. I may obtain a revised notice of the privacy practices by calling the office and requesting a copy or reviewing it electronically.

Patient or Representative Signature: ___________________________________ Date: _____________

Printed name of Patient or Representative: ____

Description of Authority/Relationship: ____